STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814

June 20, 1995

ALL-COUNTY LETTER NO. 95-27

TO: ALL COUNTY WELFARE DIRECTORS
ALL INTERSTATE COMPACT LIAISONS
ALL CDSS ADOPTIONS DISTRICT OFFICES
ALL PUBLIC AND PRIVATE ADOPTION AGENCIES
ALL COUNTY MEDI-CAL LIAISONS

REASON FOR THIS TRANSMITTAL

[ ] State Law Change
[ ] Federal Law or Regulation Change
[ ] Court Order or Settlement Agreement
[ ] Clarification Requested by One or More Counties
[X] Initiated by CDSS

SUBJECT: MEDI-CAL INFORMATION DOCUMENT FOR CALIFORNIA CHILDREN PLACED IN OUT OF STATE CARE

REFERENCE: ACL 92-09 AND ATTACHMENT PUB 99 (01-92) IS SUPERCEDED

This will serve as notification of an updated Medi-Cal Information Document PUB 99 (05/95). The document provides current information about the services covered by Medi-Cal and the procedures to be followed by out of state providers in securing payment for approved services rendered to California children placed out of state through the Interstate Compact on the Placement of Children (ICPC) and to non-federally eligible children in the Adoption Assistance Program (AAP) whose families have moved out of state. A copy of the Medi-Cal Information Document PUB 99 (05/95) is included herein for your convenience.

The updated document should accompany other related placement material once it is known that placement will occur out of state. Copies should be sent to the relative/nonrelative caretaker in the receiving state as well as to the social worker in the receiving state agency who will be supervising the placement.

The document discusses the various responsibilities of caretakers, out of state health care providers, and referring social workers or agencies. Services can be provided and claims processed in a timely manner when each participant completes his/her responsibilities. Telephone numbers of offices which specifically handle questions pertaining to provider status, prior authorization and claims processing are included in the document. The PUB 99 (05/95) also contains a listing of the current addresses of both State and Electronic Data Systems (EDS) offices which prospective or current out of state providers may consult when making an inquiry.

All Title IV-E (Federal AAP or Federal Foster Care) eligible minors, who are placed out of state, should be eligible for Medicaid in the receiving state as specified by Public Law 99-272, referred to as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Medi-Cal should continue to be provided only to nonfederally eligible minors placed out of state who have established linkage for Medi-Cal coverage, or to nonfederally eligible children participating in the

AAP whose families have relocated outside California. Medi-Cal should also continue to be provided to children placed in states that have not yet implemented the COBRA provisions.

Camera ready copies of the Medi-Cal Information Document are available and can be provided, upon request, by contacting the Forms Management Unit at (916) 657-1907 or CALNET 437-1907. When ordering, please request PUB 99 (05/95). As this is a publication, a camera ready copy will be made available without cost.

Sincerely,

MARJORIE KELLY
Deputy Director
Children and Family Services Division

Attachment

c: CWDA

MEDI-CAL INFORMATION DOCUMENT FOR CALIFORNIA CHILDREN PLACED IN OUT-OF-STATE CARE

Medi-Cal is California's name for Medicaid, the Federal Medical Assistance Program authorized by Title XIX of the Social Security Act for needy and low income persons. Beneficiaries receive a plastic Benefits Identification Card (BIC) and their eligibility is reviewed on an annual basis. Medi-Cal pays for health care for eligible California children placed in other states through the Interstate Compact on the Placement of Children (ICPC), as well as for non-federally eligible children who are receiving Medicaid as part of their Adoption Assistance Program (AAP) and who have moved out of California. Medi-Cal will pay for health care for these two groups under the following conditions:

1. When health care services proposed by the child's attending physician or other health care provider is approved in advance by the California Department of Health Services through the prior authorization process.

2. Without prior authorization when an emergency arises from an accident, injury, or illness. However, the health care provider must contact the California Department of Health Services upon admission of a Medi-Cal child, or when the facility learns of the child's Medi-Cal eligibility, in order to receive verbal approval for the services. Furthermore, upon the child's discharge, a completed Treatment Authorization Request (TAR) with all medical records must be submitted to the California Department of Health Services for approval.

Medi-Cal coverage is available for the following types of care: physician and other professional services; hospital services (inpatient and outpatient); prescription drugs and medical supplies; radiology and laboratory services; ambulance services; stays in long term care facilities; prosthetic and orthotic appliances; durable medical equipment; eye glasses and eye appliances; dental and vision services; etc. Certain procedures, however, must be followed to assure payment for such services.

Medi-Cal covers services that are reasonable and necessary to protect life, or to prevent significant disability or serious deterioration of health. The California Department of Health Services carries out this standard through various utilization controls, including prior authorization. When a provider enrolls in the Medi-Cal program, a provider manual or billing syllabus, which explains how this standard is applied, is sent to that provider.

PROVIDER IDENTIFICATION NUMBER REQUIRED

A doctor or health care provider must be approved and given a Provider Identification Number by the California Department of Health Services, before a TAR can be approved or before a claim for payment can be processed. An exception to this is the dental services provider. Please

refer to the Dental Services Section in this document. An identification number assigned by a state other than California cannot be used to bill the California Medi-Cal Program.

As of August 15, 1994, a non-Medi-Cal out-of-state provider is assigned a generic number by Electronic Data Systems (EDS) when a claim for emergency services is submitted. This will cover claims up to $599.99 per year. If the provider wishes to continuing billing to Medi-Cal, they must enroll with provider enrollment. An application is sent automatically to the provider, by EDS, when they reach their $600 limit. The California Department of Health Services will verify the provider's eligibility through the corresponding state's Medicaid or licensing agency.

Out-of-State providers can apply to be a Medi-Cal provider through provider enrollment. Obtaining a Provider Identification Number can take from one to three months because of the communications necessary between the provider, the California Department of Health Services, and the corresponding state's medical licensing agencies. For that reason, some providers are not willing to accept Medi-Cal as payment for services. It is important, therefore, that a provider willing to accept Medi-Cal is identified as soon as possible, even for a well child before health care is actually needed.

The provider should be given a copy of this Medi-Cal Information Document. After reading the document carefully, the provider may write or call the following office to request an application for a provider number:

Department of Health Services
Provider Enrollment Section
P.O. Box 942732, Room 940
Sacramento, CA 94234-7320
(916) 323-1945

When the application is received, the provider should complete the application and return it to the Provider Enrollment Section as soon as possible. The provider should write at the top of the application, preferably in red ink, "INTERSTATE COMPACT CHILD - PLEASE EXPEDITE." This will assure priority treatment of the application and a two-year period of enrollment. It is the provider's responsibility to renew provider participation biannually.

Please note that California does not enroll out-of-state physician groups, therefore each physician who has charges at this time should complete an application for enrollment. As these numbers are assigned for a limited time period, there is no need to enroll every physician in a group now, only those with charges for Medi-Cal.

If you have located a provider who is a Medi-Cal provider you should confirm their status. To verify the status of a provider number call:

Department of Health Services
Provider Enrollment/Status Desk
(916) 324-0999

PRIOR AUTHORIZATION REQUIRED

When the child is in need of routine medical care, prior authorization MUST always be obtained. This includes such services as immunization shots, physical checkups, nonemergency dental or vision care services, follow-up care to an emergency, or ongoing care for a continuing medical problem. These medical services can be planned for in advance by the caretaker and the provider. The provider must receive approval from the California Department of Health Services before treatment is provided. Approval for all nonemergency services except vision care is requested on the TAR form. The provider should write at the top of the TAR form, preferably in red ink, "INTERSTATE COMPACT CHILD-PLEASE EXPEDITE." This statement should also be written at the top of all subsequent TARs. Once the provider receives a Medi-Cal provider number, Medi-Cal may be billed for services rendered. The TAR should be completed as quickly as possible and submitted to the Out-of-State Unit of the Medi-Cal Field Office at the following address:

Department of Health Services
San Francisco Medi-Cal Field Office
Attn: Out-of-State Unit
P.O. Box 3704
San Francisco, CA 94119
(415) 904-9600

MEDI-CAL CARD INFORMATION REQUIRED

The California Department of Health Services issues a permanent plastic Benefits Identification Card (BIC), which is provided to the relative/foster parent for the child. If there is more than one child in the family, each eligible child will receive a separate card. The Medi-Cal card should always be carried when visiting the provider or hospital for any reason. The BIC will resemble the sample depicted in this publication.

The BIC, which is like a credit card, is for identification purposes only. Providers must verify eligibility every month for each recipient who presents a plastic BIC. Possession of a BIC is not proof of Medi-Cal eligibility since it is a permanent form of identification and is retained by the recipient even if he or she is not eligible for the current month.

Eligibility may be verified for the current month before the actual service if a photocopy of the recipient's BIC is kept in the files. Keep the Eligibility Verification Confirmation (EVC) number in the recipient's file. Eligibility may only be verified for the current month and up to the previous 12 months, never for future months.

Recipients eligible for Medi-Cal are allowed two Medi-Services per calendar month. Medi-Services can be reserved using a Point of Service (POS) device, Claims and Eligibility Real-Time System (CERTS) software, telephone Automated Eligibility Verification System (AEVS) or with certain vendor-supplied software packages. The POS device, CERTS software, AEVS and vendor-supplied software are ways of accessing the POS network. The POS network is set up to verify eligibility, do Share of Cost and Medi-Service transactions and bill on-line pharmacy drug claims. The following providers should reserve a Medi-Service before billing for certain services: chiropractors, psychologists, acupuncturists, podiatrists, occupational therapists, speech pathologists and audiologists. The procedure code on the reservation must match the procedure code on the claim to be reimbursed. For questions about recipient eligibility and technical assistance with POS/CERTS operation; use of the on-line system; network and equipment; service/software initialization; and service/maintenance, call (916) 636-1990 from 6:00 a.m. to midnight seven days a week.

If treatment authorization is required on an urgency basis, oral approval may be given by the Out-of-State Unit. However, the provider must follow up this oral approval by submitting a completed TAR with the patient's medical records attached. The TAR should include the treatment authorization number given orally by the Out-of-State Unit. Written authorization for the services will then be sent to the provider.

EMERGENCY SITUATIONS

Prior authorization is not required in an emergency due to accident, injury, or illness where the child's health would be endangered by postponing treatment. Emergency services are services required for alleviation of severe pain or the immediate diagnosis and treatment of unforeseen medical conditions that could lead to disability or death if not immediately treated. Providers, when billing for outpatient services rendered on an emergency basis, must complete the Emergency Certification Statement on the claim form (40-1). A TAR is not required.

All inpatient hospital stays, including emergency stays, require prior authorization from the first day. When submitting TARs, providers must include documentation indicating that the procedure was medically necessary according to the new standards and that an emergency condition existed. For emergency hospitalization, providers should obtain an oral (telephone) control number from the Out-of-State Unit as soon as possible.

CLAIMS

A claim for payment should be submitted to the Department of Health Services until the provider

has reached his/her $600 limit for the year. After enrolling with provider enrollment, claims then can be sent directly to EDS, the Medi-Cal fiscal intermediary. All claims, with the exception of dental service claims, may be submitted only on California Medi-Cal claim forms. No other billing forms, invoices, or statements can be accepted. These forms are provided at the time a Provider Identification Number is sent to the provider.

If providers (other than dental) have any questions regarding completion of the claim form, they are encouraged to call or write the appropriate EDS claims office listed below:

PLEASE RETAIN FOR FUTURE REFERENCE WHEN WORKING WITH CALIFORNIA MEDI-CAL

PROVIDER STATUS

Department of Health Services
Provider Enrollment
P.O. Box 942732, Room 940
Sacramento, CA 94234-7320
(916) 323-1945

CLAIMS FORMS NEEDED, ASSISTANCE WITH COMPLETION OF CLAIM FORMS

EDS Federal Corporation
Out of State Unit
(916) 636-1000

CLAIMS SUBMISSION

Send ALL out-of-state Medi-Cal claims and correspondence to:

EDS Federal Corporation
P.O. Box 15700
Sacramento, CA 95813-1700

GENERAL CORRESPONDENCE AND FIRST LEVEL APPEALS

EDS Federal Corporation
P.O. BOX 15300
Sacramento, CA 95851-1300
Attn: FIRST LEVEL APPEALS

ELIGIBILITY VERIFICATION

Out of state AEVS (Automated Eligibility Verification System)
EDS Federal Corporation
1-800-456-2387

RESUBMISSION TURNAROUND DOCUMENTS (RTD'S)

EDS Federal Corporation
P.O. Box 15200
Sacramento, CA 95851-1200
(916) 636-1100

CLAIMS INQUIRY FORMS (CIF'S)

EDS Federal Corporation
P.O. Box 15300
Sacramento, CA 95851-1300

All out-of-state claims must be sent to the appropriate EDS office shown above before being processed for payment.

DENTAL SERVICES

Dental services are handled separately and differently from other Medi-Cal services. Dental care providers should contact the Denti-Cal Provider Services Department at the following address for prior authorization and claims assistance:

Delta Dental Plan of California (Denti-Cal)
Denti-Cal, Provider Services Department
7667 Folsom Boulevard
Sacramento, CA 95826
(916) 386-1620

VISION CARE

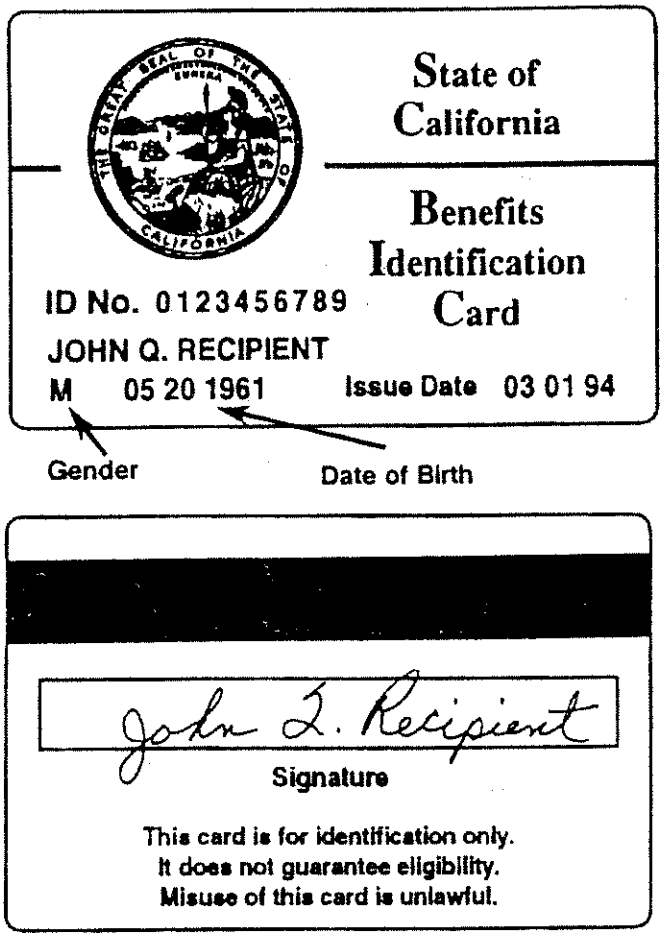
Vision care providers should contact the Vision Care Unit at the following address for prior authorization and claims assistance:

California Department of Health Services
Benefits Branch
Vision Care Unit
714 P Street, Room 1640
Sacramento, CA 95814
(916) 654-0274

If the provider experiences any difficulties with obtaining a Provider Identification Number or a treatment authorization number, or if a number is required on an urgency basis, the provider should contact the Out-of-State Unit of the California Department of Health Services at (415) 904-9600.

BENEFITS IDENTIFICATION CARD

The monthly card issued by the State of California will resemble the sample depicted below:



Sample Benefits Identification Card (BIC).
White Card with Blue Letters on Front, Black Letters on Back.

EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT REFERRALS

Code of Federal Regulations, Title 42, Part 441, Subpart B, Section 441.56, require that informing about Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services occur initially and annually thereafter by a person who can explain EPSDT services and benefits.

State regulations require that when a child is placed out of the home the social worker must ensure that information regarding available EPSDT services is made available to the out-of-home care provider within 30 days of placement. This regulation does not distinguish between those placements made within the state and those made into other states.

DIRECTIONS:

Follow Section A if:

1. Initial placement and/or change of placement require initial informing using face-to-face contact and the provision of printed material.

OR

2. There has been no change of placement and no EPSDT services were utilized during the preceding 12 months. Annual informing is to be done orally and with the provision of written materials.

Follow Section B if:

1. The child is in the same placement and receiving EPSDT services. Annual informing is to be done orally or in writing.

A. The process of initial and annual informing requires that the out-of-home foster care provider be informed in clear and nontechnical language and be given that state's EPSDT brochure. The explanation about EPSDT should include services provided, the benefits of preventive health care, where the services are available, how to obtain them and that assistance for scheduling and transportation is available. Regardless of the foster care provider's decision, documentation must include the receipt of the brochure, the response to the offer of medical and dental services, and the offer of scheduling and transportation assistance. It is the California social worker's responsibility to ensure that informing was given by the receiving state's social worker. Furthermore, the California social worker must procure a copy of the form used to document that informing took place and the foster care provider's response. The copy of this form should be maintained in the child's services case record.

B. If the child is receiving EPSDT services and has not changed placement, the foster care provider must be notified of the time the child is due to receive a health and dental examination per the receiving state's periodicity schedule (not to exceed annual preventive dental exams), offered a health or dental referral if the child is receiving only one of these EPSDT services and offered assistance with scheduling and transportation. Documentation must include the foster care provider's response to all of the foregoing. It is the California social worker's responsibility to ensure that informing was given by the receiving state's social worker. Furthermore, the California social worker must procure a copy of the form used to document that informing took place and the foster care provider's response. The copy of this form should be maintained in the child's services case record.

California's EPSDT program is administered through the Children's Medical Services Program. Before making a referral for EPSDT services in the receiving state, the California social worker must research how EPSDT is handled through that state's Medicaid program. In order for a child placed out-of-state to receive these services under Medi-Cal, the EPSDT provider must become a Medi-Cal provider (see section entitled, Provider Identification Number Required).

SUMMARY OF ROLES FOR PARTICIPANTS IN INTERSTATE COMPACT FOR CHILDREN PLACEMENTS INVOLVING MEDI-CAL

SOCIAL WORKERS, RELATIVES AND FOSTER PARENTS should be aware that:

1. Not all health care providers accept Medi-Cal for payment of health services or are willing to participate in the program.

2. Prior authorization from the California Department of Health Services is necessary for all treatment except emergencies.

SOCIAL WORKERS should take the following actions:

1. Encourage early selection of a personal physician for the child who is willing to accept Medi-Cal payment for services.

2. Provide the Medi-Cal Information Document to relative and nonrelative caretakers and physician.

3. Assure the child has a Medi-Cal BIC. Contact the California social worker if the card has not been received by the care provider or if there are problems with the child's eligibility.

4. Social workers in the receiving state must: inform the out-of-home foster care provider of the services and benefits of EPSDT; provide that state's EPSDT brochure; document the provision of the brochure and the foster care provider's response on the appropriate form; make the referral, if services are requested, to the receiving state's EPSDT unit; and provide a copy of the form to the California social worker.

5. California social workers must ensure that the social worker in the receiving state has executed and documented the initial or annual informing process, and is maintaining a copy of the informing document in the child's services case record.

6. Obtain assistance with problems as necessary from the California Department of Health Services.

RELATIVES AND FOSTER PARENTS should take these actions:

1. Secure a personal physician for the child who is willing to accept Medi-Cal payment for services as soon as possible.

2. Provide the doctor with the Medi-Cal Information Document.

3. Preplan routine or ongoing treatment with the doctor.

4. Always take the child's Medi-Cal BIC to the doctor's office or health care facility.

5. Contact the social worker with any problems about Medi-Cal as soon as possible, especially if a BIC has not been received or if there are any problems with eligibility.

PHYSICIANS AND OTHER HEALTH CARE PROVIDERS SHOULD BE AWARE THAT:

1. A Provider Identification Number is required for all health care providers before a claim for payment can be processed. It can take up to three months to obtain this number from California.

2. The state of California does not enroll out-of-state physician groups. Therefore, each physician who anticipates charges must enroll as a medical provider.

3. Prior authorization is required from California for all inpatient stays and for all nonemergency outpatient services.

4. Each claim for payment must have the recipient's name and an Eligibility Verification Confirmation (EVC) number for each service.

5. Claims are computer processed which require their submission on the California Medi-Cal claim form. Any questions regarding their completion or status, once mailed, should be directed to our fiscal intermediary, EDS, at (916) 636-1960.

6. Treatment authorization is required in most instances. If it is required, a claim will not be considered for payment without it. You should contact the Medi-Cal Field Office for authorization and information at (415) 904-9600.

7. If you need assistance completing the application or have questions about your enrollment, contact Provider Enrollment at (916) 323-1945 and ask for the Out-of-State Representative.

8. Dental care providers must contact Denti-Cal, Provider Services Department, for prior authorization and claims assistance at (916) 386-1620.

9. Vision care providers must contact the Department of Health Services Benefits Branch for prior authorization and claims assistance at (916) 654-0274.

PHYSICIANS AND OTHER HEALTH CARE PROVIDERS SHOULD TAKE THE FOLLOWING ACTIONS:

1. Apply for a Provider Identification Number from California as soon as possible.

2. Obtain prior authorization for all treatment except emergencies. Emergency services require verbal authorization and upon discharge, a completed TAR with medical records.

3. Write in red ink at the top of the "Application for Provider Identification Number," and "Treatment Authorization Request."

   "INTERSTATE COMPACT CHILD - PLEASE EXPEDITE"

4. Photocopy the child's plastic BIC and obtain an Eligibility Verification Confirmation (EVC) number each time the patient is treated.

5. Promptly submit claims for payment on proper Medi-Cal claim forms, with the recipient's name and an Eligibility Verification Confirmation (EVC) number for each service.

6. Contact the patient's relative/foster parent or social worker with any problems.